PROVIDER REQUEST FOR AN ADJUSTMENT

ND DEPARTMENT OF HUMAN SERVICES

SFN 639 (Rev. 08-2002)

STATE USE ONLY

(1) Reason for Request:

☐ A. No Payment Received ☐ B. Overpayment ☐ C. Underpayment ☐ D. Corrected Billing Attached
☐ E. Paid to Wrong Provider ☐ F. Cannot Identify Beneficiary on Explanation of Benefits ☐ G. Lost Check
☐ H. Other (Please Clarify Under Remarks)

(2) Recipient Block:

a. I.D. Number (9 digits)

b. State Use Only
Base ID

c. Patient's Name

d. Case Number (10 digits)

(4) Claim's Internal Control Number: (13 digits)

(3) Provider's Name:

(5)

Address

(6) Provider Number:

City | State | Zip Code

(7) Remittance Advice Date: (MM/DD/YY)

(8) Date of Service: From Mo	Day	Yr	Thru Mo	Day	Yr	**(9) Units**	**(10) Place of Service**	**(11) Procedure/Ancillary/ Accommodation**	**(12) Mod**	**(13)Tooth No./ Tooth Sur.**	**(14) Amount Billed**		**(15) Amount Paid**	
(17) Explanation/Remarks:									**(16) Total**		$		$	

Medical Services
N.D. Department of Human Services
600 E. Boulevard Ave Dept 325
Bismarck, ND 58505-0250

(19) Provider's Signature:

Date (MM/DD/YY) | Provider

Telephone Number

By